DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 1 6

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 7,397
b. FFY 2002 $ 7,397

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A Pages 1 through 35

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A Pages 1 through 35

10. SUBJECT OF AMENDMENT:
Changes to the inpatient hospital and inpatient psychiatric residential treatment facility reimbursement methodologies and the disproportionate share program.

GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
William A. Prince

14. TITLE:
Director

15. DATE SUBMITTED:
December 18 2000

16. RETURN TO:
South Carolina Department
of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 29, 2000

18. DATE APPROVED:
June 14, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Craener

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL AND PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CARE

I. General Provisions

A. Purpose

This plan establishes a prospective payment reimbursement system for inpatient hospital services and inpatient psychiatric residential treatment services in accordance with the Code of Federal Regulations. It describes principles to be followed by Title XIX inpatient hospital and psychiatric residential treatment providers and presents the necessary procedures for setting rates, making adjustments, auditing cost reports and managing the hospital disproportionate share program.

B. Objectives

Pursuant to the requirements of the Omnibus Budget Reconciliation Act (OBRA) of 1981 that provider reimbursements be reasonable and adequate to assure an efficient and economically operated facility, the prospective rate plan herein described will apply.

Effective October 1, 1997, the Balanced Budget Act (BBA) of 1997 repeals the OBRA 1981 requirement stated above. In its place, the BBA of 1997 provides for a public process for determination of hospital payment rates. This public process will take place for all changes in payment for inpatient hospital and psychiatric residential treatment facility services and disproportionate share.

C. Overview of Reimbursement Principles

1. Effective January 1, 1986, the South Carolina Medicaid Program will reimburse qualified providers for inpatient institutional services based solely on the prospective payment rates developed for each facility as determined in accordance with this plan. Prospective payments in the aggregate will not exceed the amount that would have been paid under Medicare principles of reimbursement.

2. Prospective rates shall be payment in full for each Medicaid discharge. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient

stay, except as provided in Section III of this plan. Hospitals may submit a claim for payment only upon final discharge of the patient, with the exception of long-term care psychiatric hospital claims and psychiatric residential treatment facility claims.

3. All inpatient services associated with admissions occurring on or after January 1, 1987, furnished by hospitals, are subject to the Hybrid prospective payment system. Special prospective payment system provisions are included for services provided by freestanding long-term care psychiatric hospitals.

4. Payment for all hospitals except those identified in 3 above will be made based on a Hybrid system which compensates hospitals either an amount per discharge (per case) for a diagnosis related group or a prospective per diem rate. DRG categories that are frequent, relatively homogeneous and considered by clinical experts not to be of a highly specialized nature will be paid an amount per discharge for each DRG category. DRG categories that are infrequent, highly variant and/or are considered by clinical experts to be of a highly specialized nature will be paid a hospital-specific per diem rate appropriate for the type of service rendered.

5. For discharges paid by the per case method under the Hybrid System, South Carolina specific relative weights and rates will be utilized. The DRG classification system to be used will be the classification system currently used by the Medicare program. The relative weights will be established based on a comparison of charges for each DRG category to charges for all categories. South Carolina's historical Medicaid claims database will be used to establish the DRG relative weights.

6. For discharges paid by the per diem method, an appropriate hospital-specific per diem rate will be established for the type of service. The per diem rate will distinguish routine, special care, and neonatal intensive care days and will further distinguish these into surgery and non-surgery cases. Facilities will receive the appropriate per diem rate times the number of days of stay, subject to the limits defined in this plan.

7. An outlier set-aside adjustment (to cover outlier payments described in 10 of this section) will be made to the per discharge rates.

8. Payment for services provided in freestanding long-term care psychiatric facilities shall be based on the statewide average per diem for psychiatric long-term care. The base per diem rate will be the statewide total costs of these psychiatric services divided by total psychiatric days.

9. The prospective payments determined under both payment methods, the Hybrid prospective payment system for general acute care hospitals, distinct part units and short term care psychiatric hospitals and the per diem method for psychiatric long-term care facilities will be adjusted to recognize facility specific costs associated with

direct and indirect medical education, capital and ancillary services as appropriate. Capital and direct medical education will be reimbursed prospectively on an interim basis, and retrospectively settled at a future date. Disproportionate share hospitals will not be eligible for cost settlements in accordance with the upper payment limit requirements of the OBRA 1993. Effective October 1, 1999, South Carolina Department of Mental Health hospitals will be reimbursed 100% of their allowable Medicaid inpatient cost through a retrospective cost settlement process.

10. Special payment provisions, as provided in Section VI A of this plan, will be available under the Hybrid prospective payment system for discharges paid by DRG which are atypical in terms of patient length of stay or costs of services provided during the stay. These cases will be referred to as outliers. Special payment policies, as specified in Section VI C and D of this plan, will also be made for cases involving a transfer of a patient from one hospital to another, or a readmission of a patient following an earlier discharge. These provisions are not applicable to long-term psychiatric and RTF claims.

11. Reduced payment, as specified in Section VI B of this plan, will be made for cases paid on a per diem basis having stays exceeding two hundred percent of the hospital specific average length of stay.

12. A rate reconsideration process will be available to hospitals which have higher costs as a result of conditions described in VIII B of this plan.

13. Disproportionate share payments will be paid to qualifying hospitals in accordance with the requirements specified in Section VII of this plan.

14. Payment for services provided in psychiatric residential treatment facilities shall be an all-inclusive per diem rate. Section II paragraph 29 of this plan defines the costs covered by the all-inclusive rate. Each facility's per diem rate will be calculated using base year data trended forward. Section V B describes the rate calculation.

15. Effective October 1, 1998, reimbursement for statewide pediatric telephone triage services will be available for the designated South Carolina Children's Hospitals. Payment will be based on the Medicaid portion of allowable service cost.

16. Effective October 1, 1999, a small hospital access payment will be paid to qualifying hospitals that provide access to care for Medicaid clients.

17. Effective October 1, 1999, a high volume Medicaid adjuster payment will be paid to hospitals that serve a significantly high volume of Medicaid patients.

18. Effective October 1, 2000, hospitals participating in the SC Universal Newborn Hearing Screening, Detection, and Early Intervention Program will be reimbursed for Medicaid newborn hearing screenings. Effective July 1, 2001, all hospitals will be eligible for this reimbursement.

II. Definitions Applicable to Inpatient Hospital and Residential Treatment Facility Reimbursement

The following definitions will help in understanding the payment rates set for inpatient hospital and residential treatment facility services:

1. Administrative Days - The days of service provided to recipients who no longer require acute hospital care, but are in need of nursing home placement that is not available at the time. The patient must meet either intermediate or skilled level of care criteria.

2. Arithmetic Mean (average) - The product of dividing a sum by the number of its observations.

3. Base Year - The fiscal year used for calculation of prospective payment rates. For rates effective October 1, 1993 the base year shall be each facility's 1990 fiscal year. Where 1990 cost reports are not finally audited, an adjustment factor, as described in Section IV of this plan, will be utilized.

4. Capital - Cost associated with the capital costs of the facility. For purposes of the prospective payment methodology, capital costs include, but are not limited to, depreciation, interest, property taxes, property insurance, and directly assigned departmental capital lease costs.

5. Case-Mix Index - A relative measure of resource utilization at a hospital.

6. Cost - Total audited allowable costs of inpatient services, unless otherwise specified.

7. CRNA - Certified Registered Nurse Anesthetist.

8. Diagnosis Related Groups (DRGs) - A patient classification that reflects clinically cohesive groupings of patients who consume similar amounts of hospital resources.

9. Direct Medical Education Cost - Those direct costs associated with an approved intern and resident or nursing school teaching program as defined in the Medicare Provider Reimbursement Manual, publication HIM-15.

10. Discharge - The release of a patient from an acute care facility. The following patient situations are considered discharges under these rules.

    a. The patient is formally released from the hospital.

    b. The patient is transferred to a long-term care level or facility.

    c. The patient dies while hospitalized.

d. The patient leaves against medical advice.

e. In the case of a delivery, release of the mother and her baby will be considered two discharges for payment purposes. In case of multiple births, each baby will be considered a separate discharge.

f. A transfer from one hospital to another will be considered a discharge for billing purposes but will not be reimbursed as a full discharge except as specified in Section VI. Cases involving discharges from one unit and admission to another unit within the same hospital for the same period of hospitalization shall be recognized as one discharge for payment purposes. The DRG assignment for each case will be assigned based on services provided at the point of discharge.

11. Disproportionate Share Hospitals - South Carolina contracting acute care inpatient hospitals whose participation in the Medicaid program and services to low income clients is disproportionate to the level of service rendered in other participating hospitals shall be considered disproportionate share hospitals.

Hospitals must satisfy **one** of the following criteria in order to qualify for the SC Medicaid disproportionate share hospital (DSH) program. The first 3 qualifying criteria will be based on an average of 3 years of data beginning with the 1997 base year. During the transition period, hospitals qualifying for disproportionate share in SFY 1999 will be grandfathered into the DSH program while 3 years of data is accumulated.

a. Hospitals with a Medicaid utilization percentage (as measured by patient days) greater than 100% of the statewide average. The statewide average includes contracting border hospitals.

b. Hospitals with a low-income utilization percentage in excess of 22%.

c. Hospitals with SC Medicaid newborn discharges greater than 200% of the statewide average.

d. South Carolina state-operated and state-supported teaching hospitals with an approved intern and resident program.

In addition, hospitals must satisfy the next 3 criteria in order to qualify for the SC Medicaid disproportionate share hospital (DSH) program:

e. Hospitals must adhere to the DHHS's administrative time frames for submitting data.

f. Hospitals must have a Medicaid day utilization percentage of at least one percent.

g. Hospitals must have at least two (2) obstetricians with staff privileges who have agreed to provide obstetrical services to Medicaid patients on a non-emergency basis. Staff privileges is defined as an obstetrician or other physician who is a Medicaid provider and is on the active staff of a hospital, who admits patients on a regular basis and routinely provides obstetric services at that hospital. This rule does not apply to a hospital that did not offer non-emergency obstetric services to the general population as of December 22, 1987.

Information will be collected at a point in time specified by the DHHS and will be used to determine which hospitals qualify for disproportionate share. Financial and statistical information used to determine disproportionate share qualification and payment will be submitted and/or verified on Medicaid supplemental worksheets. The supplemental worksheets must be completed correctly. Hospitals that fail to submit verifiable data within the time frame specified will not meet the qualifications for a disproportionate share hospital. Data may be reviewed by a peer review system specified in Section VII (B) (2). Data will be verified by the DHHS using appropriate sources, including, but not limited to, the HCFA 2552 and the DHHS inpatient MARS report and administrative days report. Disproportionate share eligibility does not qualify for the rate reconsideration process.

Disproportionate share payment will be based on a prospective payment system. The disproportionate share payment methodology is set forth is Section VII A.

Effective October 1, 1992, all SC disproportionate share hospitals must agree to and sign a Disproportionate Share Memorandum of Agreement with the DHHS.

12. General Acute Care Hospital - An institution licensed as a hospital by the applicable South Carolina licensing authority and certified for participation in the Medicare (Title XVIII) program.

13. High Volume Medicaid Hospital - A hospital with South Carolina Medicaid inpatient days greater than 35,000 as reported on the hospital fiscal year 1997 MARS Report.

14. Indirect Medical Education Cost - Those indirect costs resulting from the additional tests and procedures performed on patients because the hospital is a teaching institution. Such costs are determined using the number of interns and residents per operating bed in a Federally derived indirect medical education equation.

15. Indirect Medical Education Percentage - The percentage used to calculate indirect medical education cost. It is derived from the following formula:

$$1.43 \times (((1 + (\text{interns and residents})/\text{beds})^{.5795}) - 1)$$

16. Inpatient - A patient who has been admitted to a medical facility on the recommendation of a physician or a dentist and who is receiving room, board and professional services in the facility. A patient who is admitted to an acute care facility and expires while in the facility shall be considered an inpatient admission regardless of whether the stay was overnight.

17. Inpatient Services - Those items and services ordinarily furnished by a hospital for the care and treatment of patients. These items and services are provided under the direction of a licensed practitioner in accordance with hospital by-laws. Such inpatient services must be medically justified documented by the physician's records and must comply with the requirements of the state's designated Peer Review Organization (PRO). Emergency room services are included in the PPS inpatient rate only when a patient is admitted from the emergency room.

18. Intensive Technical Services - Those services rendered to patients having extreme medical conditions requiring total dependence on a life support system.

19. Long-Term Care Psychiatric Hospital - An institution licensed as a hospital by the applicable South Carolina licensing authority, certified for participation in Medicare XVIII program, primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons with a Medicaid inpatient acute average length of stay greater than twenty-five (25) days.

20. Low Income Utilization Rate - The sum of fractions a and b.

    a. Numerator:

    Total Medicaid inpatient and outpatient charges, including charges for Medicaid managed care patients, plus cash subsidies for patient services received directly from state and local governments.

    Denominator:

    Total inpatient and outpatient charges (including cash subsidies) for patient services.

    b. Numerator:

    Total hospital charges for inpatient hospital services attributable to charity care less cash subsidies from "a" above.

    Denominator:

    Total inpatient charges for patient services.

    Cash subsidies are defined as monetary contributions or

donations received by a hospital. These contributions must originate from state and local governments. All contributions received will be considered as cash subsidies. If the funds are not designated for a specific type of service (i.e. inpatient services), they shall be prorated based on each type of service revenue to the hospital's total revenue (i.e. total inpatient revenues divided by total patient revenues).

Charity care is defined as care provided to individuals who have no source of payment, third party or personal resources. Total charges attributable to charity care shall not include contractual allowances and discounts or charges where any payment has been received for services rendered. An individual application, client specific, must be taken and a decision rendered in each applicant's case.

21. Medicaid Day Utilization Percentage - A facility's percent of hospital Medicaid inpatient acute days, including Medicaid managed care days, plus administrative days divided by total hospital inpatient acute days plus administrative days. The source of patient day information will be the filed HCFA 2552 worksheet S-3, DHHS's MARS report, DHHS's administrative days report and requested supplemental worksheets.

22. Medically Necessary Services - Services which are necessary for the diagnosis, or treatment of disease, illness, or injury, and which meet accepted standards of medical practice. A medically necessary service must:

    a. Be appropriate to the illness or injury for which it is performed as to type and intensity of the service and setting of treatment;

    b. Provide essential and appropriate information when used for diagnostic purposes; and

    c. Provide additional essential and appropriate information when a diagnostic procedure is used with other such procedures.

23. Outliers - There are two kinds of outliers: day outliers and cost outliers. A day outlier occurs when the patient's length of stay exceeds a specified amount. A cost outlier occurs when a patient's charges exceed a specified amount. In both cases, the hospital will receive reimbursement for the outlier in addition to the base DRG payment. Outliers only apply to claims paid per discharge.

24. Outpatient - A patient who is receiving services at a hospital which does not admit him/her and which is not providing him/her with room and board services.

25. Outpatient Services - Those diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to an outpatient by an institution

licensed and certified as a hospital. This service will include both scheduled services and the provision of service on an emergency basis in an area meeting licensing and certification criteria.

26. Pediatric Telephone Triage Services - Services provided by qualified medical personnel to assist callers in determining the nature of a child's medical problem and the appropriate action to take (e.g. see a physician the next day, go immediately to an emergency room, etc.). This service is available for parents or caretakers of SC Medicaid children 0 through 18 years old.

27. Principal Diagnosis - The diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital.

28. Psychiatric Distinct Part - A unit where psychiatric services are provided within a licensed and certified hospital. Patients in these units will be reimbursed through the Hybrid PPS.

29. Psychiatric Residential Treatment Facility - An institution primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons who require less than hospital services. Medicare certification is not required. Effective April 1, 1994 in-state psychiatric residential treatment facilities are required to be licensed by DHEC in order to receive Medicaid reimbursement as described in State Plan Attachment 3.1-C, page 8.

    Residential Treatment Facilities are neither acute care nor long-term care facilities. A Psychiatric Residential Treatment Facility is a facility that is accredited by the Joint Commission of Accreditation of Health Care Organizations (JCAHO), operated for the primary purpose of providing active treatment services for mental illness in a non-hospital based residential setting to persons under 21 years of age. Facilities must meet the federal regulations for inpatient psychiatric services at 42 CFR 440.160 and Subpart D for Part 441. Length of stay in a Psychiatric Residential Treatment Facility may range from one (1) month to more than twelve (12) months depending upon the individual's psychiatric condition as reviewed every 30 days by a physician.

30. Residential Treatment Facility All-Inclusive Rate - The all-inclusive rate will provide reimbursement for all treatment related to the psychiatric stay, psychiatric professional fees, and all drugs prescribed and dispensed to a client while residing in the Residential Treatment Facility.

31. Short Term Care Psychiatric Hospital - A licensed, certified hospital providing psychiatric services to patients with average lengths of stay of twenty-five (25) days or less. Patients in these hospitals will be reimbursed through the Hybrid PPS.

32. Small Hospital Access Payment - A payment for Medicaid participating